

NEBRASKA CRIME VICTIM’S REPARATIONS COMMITTEE

CLAIM FOR COMPENSATION

Section 1. VICTIM INFORMATION (All applicants MUST complete this section)

Name (Last) (First) Middle Initial			Social Security Number
Street or Other Mailing Address		City	State Zip Code
Telephone Number ()	Date of Birth	Age at Time of Incident	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Occupation at Time of Incident		Place of Employment at Time of Incident	
Martial Status	If Married, Spouse’s Name		Number of Dependents
FEDERAL CIVIL RIGHTS INFORMATION: The Department of Justice is requiring us to collect the following data. This information is used for statistical purposes only and will remain confidential. It is needed to comply with Federal regulations. (Information relates to victim only) Ethnic Group: _____ Asian or Pacific Islanders _____ White _____ Hispanic (Mexican, Puerto Rican, Cuban, _____ Black (Not of Hispanic Origin) or other Spanish culture) _____ American Indian or Alaskan Native National origin: _____ (Country of birth)			
WAS THE VICTIM HANDICAPPED BEFORE THIS CRIME OCCURRED? <input type="checkbox"/> No <input type="checkbox"/> Yes (Explain)		IS THE VICTIM HANDICAPPED AS A RESULT OF THIS CRIME? <input type="checkbox"/> No <input type="checkbox"/> Yes (Explain)	
Deceased Victim’s Place of Death (City/State)		Date of Death (Send Copy of Death Certificate)	

Section 2. CLAIMANT INFORMATION

Complete this section if **YOU** are filing the claim for a victim who is deceased, incapable, or a minor (under age 18) or if you have incurred an actual financial loss as a direct result of the crime.

Your Name (Last) (First) (Middle Initial)			Your Social Security Number
Your Street or Other Mailing Address		City	State Zip Code
Your Telephone Number ()	Your Date of Birth	Your Martial Status	Your Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Your Occupation		Your Place of Employment	
Your Relationship to the Victim: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other (Explain)			
Are you dependent on the victim for: <input type="checkbox"/> Principal Support <input type="checkbox"/> Child Support <input type="checkbox"/> Not Dependent on Victim <input type="checkbox"/> Other (Explain)			

COMPLETE INFORMATION ON BACK SIDE

Section 6. LOSS OF WAGE INFORMATION (Are you the victim? ☐ Yes ☐ No)

Are you claiming loss of wages? ☐ Yes ☐ No

If yes to both questions, complete the following and enclose **three** payroll stubs and a copy of your doctor’s release.

Number of days or hours missed due to crime		Date released from doctor’s care (Attach copy of doctor’s release)	
Name of victim’s employer		Employer’s Telephone Number ()	
Employer’s Business Address	City	State	Zip Code
Dates Absent From Work due to Crime Related Injuries: From _____ To: _____			
NOTE: If you are self-employed, you must furnish us with copies of estimates, bids, contracts, or your tax return from last year to accurately determine lost wages. Did you received any payment from sources such as sick pay, vacation pay, Worker’s Compensation, etc. while you were absent from work for crime related injuries? ~ Yes ~ No If yes, please explain:			

Section 7. AMOUNT OF YOUR CLAIM (All applicants **MUST** complete this section)

Note: You do not need to wait until you receive all medical bills before you complete this section. Enter total amounts for the bills you currently have which are related to the crime.

You **MUST SUBMIT itemized copies** of medical and/or funeral bills. If claiming loss of wages, see instruction sheet. If claim is approved you will be reimbursed **only** for those expenses incurred which are not paid by another source, such as insurance.

1.	Total Hospital Bills	\$	_____
2.	Total Doctor’s and Ambulance Bills	\$	_____
3.	Total Prescription (Drug) Bills (Other than those prescribed in hospital)	\$	_____
4.	Funeral Expense (Include copy of death certificate)	\$	_____
5.	Amount of income lost as a result of the incident	\$	_____
6.	Other expenses not covered above (EXPLAIN) (Property loss and Pain & Suffering not covered)	\$	_____
TOTAL AMOUNT OF CLAIM		\$	_____

Will there be additional medical bills? ☐ Yes ☐ No ☐ Unknown

Section 8. All applicants seeking compensation for medical bills must complete the following information.

Have you received any money from the following sources to pay for expenses related to the crime?

Source of Compensation	Yes	No	Unknown	Name of Insurance Company/Policy Number
Private Insurance				
Group Insurance				
Medicaid (Title 19)				
Medicare				
Worker’s Compensation				
Other (please specify)				

Have you applied for any other public assistance? Yes No

COMPLETE INFORMATION ON BACK SIDE

Section 9. IMPORTANT - READ CAREFULLY

This authorization is an integral part of your application and must be **completed, signed, and notarized** before any action will be taken on your claim.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any hospital, physician, medical facility, mental health provider or other person who attended or examined the victim; any funeral home or other person who rendered services; any employer of the victim; any law enforcement or other state/federal governmental agency; and any insurance company or organization having knowledge, to furnish the Nebraska Crime Victim’s Reparations program or its representative, confidential information with respect to the incident leading to the victim’s personal injury or death and the claim made herewith for compensation. A photocopy of this signed release is as effective and valid as the original.

I furthermore understand that any recovery of my losses through restitution/reimbursement from the offender, a civil suit, insurance or from any other governmental or private agency shall entitle the Nebraska Crime Victim’s Reparations program to be reimbursed for any compensation awarded me by the Nebraska Crime Victim’s Reparations program. The undersigned swears or affirms the information contained herein is true to his/her best knowledge. **I understand that the filing of false information is an offense punishable by law.**

Victim or Claimant Signature
(Parent/Guardian if victim/claimant/dependent is a minor)

SWORN BEFORE ME THIS _____ DAY OF _____, 2 _____

NOTARY PUBLIC: _____

Return this form to:

Nebraska Crime Victim’s Reparations Program
PO Box 94946
Lincoln, Nebraska 68509-4946

Telephone: (402) 471-2828 or (402) 471-2194

Location: Nebraska Crime Commission
301 Centennial Mall South
14th & M Streets
Lincoln, Nebraska

CHECKLIST

1. Did you complete **ALL** sections of application form which related to your claim?
2. Have you completed the Financial Resources Form?
3. Have you attached itemized copies of bills for which compensation is being claimed?
4. If claiming loss of wages, have you attached a copy of your doctor’s release stating the exact day you could return to work? Have you included 3 copies of check stubs or last year’s income tax form?
5. If claiming funeral expenses, have you attached a copy of the death certificate?
6. Have you signed the application form?
7. Has the application been notarized?

If you need help or have questions, please call (402) 471-2828.